Documentation

CPTBC
College of Physical Therapists of British Columbia

STANDARD

The physical therapist maintains client records that are accurate, legible, and complete, written in a contemporaneous manner.

EXPECTED OUTCOME

Clients can expect that their physical therapy records are accurate, legible, and complete, and reflect the physical therapy services provided.

PERFORMANCE EXPECTATIONS

The physical therapist:

1. Maintains legible, accurate, and complete client records related to all aspects of client care in either French or English.
2. Completes documentation contemporaneously to promote client safety and effective clinical care.

COMPONENTS OF A COMPLETE CLIENT RECORD

The physical therapist:

3. Confirms that the following information is retained as part of a complete client record:
   - 3.1 details of clinical care
   - 3.2 records of client attendance, including declined, missed or cancelled appointments
   - 3.3 financial records
   - 3.4 details or copies of verbal or written communication with or about the client

DETAILS OF CLINICAL CARE

The physical therapist:

4. Includes in the client record detailed chronological information including but not limited to:
   - 4.1 unique client identifier on each discrete part (each page) of the client record;
   - 4.2 client's reason for attendance;
   - 4.3 client's relevant health, family, and social history;
   - 4.4 date of each treatment session or professional interaction including declined, missed or cancelled appointments, and each telephone or electronic contact;
   - 4.5 date of chart entry if different from date of treatment session or professional interaction;
   - 4.6 assessments and findings;
   - 4.7 treatment plan and goals;
   - 4.8 informed client consent and details of the informed consent process relevant to the clinical situation;
   - 4.9 details of treatment provided and the client's response to treatment, including results of reassessments, in sufficient detail to allow the client to be managed by another physical therapist;
   - 4.10 details of tasks assigned to physical therapist support workers;
   - 4.11 details of all client education, advice provided and communication with or about the client.
5. Ensures that the individual delivering physical therapy services is clearly identified for each interaction.
6. Retains or ensures ongoing access to copies of care pathways or protocols in addition to client records in circumstances where client care delivery and documentation is according to a protocol.

QUALITY OF DOCUMENTATION

The physical therapist:

7. Confirms that documentation entered into the treatment record accurately reflects the assessment, treatment, advice, and client encounter that occurred.
8. May reference rather than duplicate information collected by another regulated healthcare provider that the physical therapist has verified as current and accurate.
9. Uses terms, abbreviations, acronyms, and diagrams which are defined or described to promote understanding for others who may access a client's record.
10. Documents changes or additions made to the client record and identifies who made the change and the date of the change.

FINANCIAL RECORDS

The physical therapist:

11. Maintains accurate and complete financial records related to the provision of physical therapy services and sales of products.
12. Financial records must include:
    - 12.1 identification of the service provider(s) and organization, date of service, and physical therapy service or product provided;
    - 12.2 client's unique identification;
    - 12.3 fee for a physical therapy service or product, including any interest charges or discounts provided;
    - 12.4 method of payment, date payment was received, and identity of the payer; and
    - 12.5 any balance owing.

ELECTRONIC MEDICAL RECORDS

The physical therapist:

13. Employs appropriate safeguards to protect the confidentiality and security of information, including but not limited to, ensuring:
    - 13.1 an unauthorized person cannot access identifiable health information on electronic devices;
    - 13.2 screen lock features are employed so that confidential information is not displayed indefinitely;
    - 13.3 each authorized user can be uniquely identified;
    - 13.4 each authorized user has a documented access level based on their role;
    - 13.5 appropriate password controls and data encryption are used;
    - 13.6 audit logging is always enabled such that access and alterations made to the client record clearly identify the date of access or change, the change or addition made, and the identity of the individual accessing or changing the record;
    - 13.7 where electronic signatures are employed, the authorized user can be authenticated;
    - 13.8 identifiable health information is transmitted or remotely accessed securely with consideration given to the risks of non-secured structures;
    - 13.9 secure backup of data occurs consistently;
    - 13.10 data recovery protocols are in place and regularly tested;
    - 13.11 data integrity is protected such that information is accessible;
    - 13.12 practice continuity protocols are in place in the event that information cannot be accessed electronically; and
    - 13.13 when hardware that contains identifiable health information is disposed of, all data is removed and cannot be reconstructed.

RELATED STANDARDS OF PRACTICE

- **Assessment, Diagnosis, Treatment**
- **Funding, Fees and Billing**
- **Informed Consent**
- **Privacy and Record Retention**